4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found (Continued)

(10) Hearing Aid Dealers

Hearing aid vendors are reimbursed at 68% of retail price. Maintenance and repairs are reimbursed according to the lesser of the amount billed not to exceed a maximum of $100.00 per repair/ maintenance.

Effective for dates of service on or after May 1, 2002, reimbursement is based on a negotiated statewide contract bid.

(11) Audiologist Services

Reimbursement is based on the lesser of the amount billed or the maximum Title XIX (Medicaid) charge allowed. The Title XIX (Medicaid) maximum is 66% of the Physician's Blue Shield Fee Schedule dated October 1, 1993.

At the beginning of each calendar year, the State Agency will negotiate with the affected provider group representatives to arrive at a mutually acceptable increase or decrease from the maximum rate. Market forces, such as private insurance rates, medical and general inflation figures, changes in practice costs and changes in program requirements, will be considered during the negotiation process. Any agreed upon increase or decrease will be implemented at the beginning of the following State Fiscal Year, July 1, with any appropriate State Plan changes.

(12) Hearing Aids

Reimbursement based on 68% of retail price.

Effective for dates of service on or after May 1, 2002, reimbursement is based on a negotiated statewide contract bid.

Withdrawn dated 5/1/02 per letter dated

6.d. Other Practitioner's Services (Continued)

(5) Psychologist Services

Refer to Attachment 4.19-B, Item 4.b. (17).

(6) Obstetric-Gynecologic and Gerontological Nurse Practitioner Services

Reimbursement is the lower of the amount billed or the Title XIX maximum allowable.

The Title XIX maximum is based on 80% of the physician fee schedule except EPSDT procedure codes. Medicaid maximum allowables are the same for all EPSDT providers. Immunizations and Rhogam RhoD Immune Globulin are reimbursed at the same rate as the physician rate since the cost and administration of the drug does not vary between the nurse practitioner and physician.

Refer to Attachment 4.19-B, Item 27, for a list of the nurse practitioner pediatric and obstetrical procedure codes.

7. Home Health Services

a. Intermittent or part-time nursing services furnished by a home health agency or a registered nurse when no home health agency exists in the area; and

b. Home health aide services provided by a home health agency

Reimbursement on basis of amount billed not to exceed the Title XIX (Medicaid) maximum.

The initial computation (effective July 1, 1994) or the Medicaid maximum for home health reimbursement was calculated using audited 1990 Medicare cost reports for three high volume Medicaid providers, Medical Personnel Pool, Arkansas Home Health, W. M. and the Visiting Nurses Association. For each provider, the cost per visit for each home health service listed above in items 7.a. and b. was established by dividing total allowable costs by total visits. This figure was then inflated by the Home Health Market Basket Index in Federal Register #129, Vol. 58 dated July 8, 1993- inflation factors: 1991 - 105.7%, 1992 - 104.1%, 1993 - 104.8%. The inflated cost per visit was then weighted by the total visits per providers' fiscal year (i.e., the visits reported on the 1990 Medicare cost reports) to arrive at a weighted average visit cost.

7. Home Health Services (Continued)
a. and b. (Continued)

For registered nurses (RN) and licensed practical nurses (LPN) the Full Time Equivalent Employees (FTEs) listed on cost report worksheet S-1, Part II, were used to allocate nursing costs and units of service (visits). It was necessary to make these allocations because home health agencies are not required by Medicare to separate their registered nurses and licensed practical nurse costs or visits on the annual cost report.

RN and LPN salaries and fringes were separated using an Office of Personnel Management Survey, which indicated that RNs, on an average, are paid 36% more than licensed practical nurses. Conversely, if RNs are paid 36% more than LPNs, then LPNs are paid, on an average, 73.5% of what RNs earn. Cost report salaries and fringes were allocated based on 100% of RN FTEs and 73.5% of LPN FTEs. Other costs and service units (visits) were allocated based on 100% of RN FTEs and 100% of LPN FTEs. RN and LPN unit service (visit) costs were then inflated and weighted as outlined above.

Since home health reimbursement is based on audited costs, the home health rates will be adjusted annually by the Home Health Market Basket Index. This adjustment will occur at the beginning of the State Fiscal Year, July 1. Every third year, the cost per visit will be rebased utilizing the most current audited cost report from the same three providers and using the same formula described above to arrive at a cost per visit inflated through the rebasing year. (The first rebasing will occur in 1996 to be effective July 1, 1997.)

c. Medical Supplies, Equipment and Appliances Suitable for Use in the Home

(1) Medical Supplies

Effective for dates of service on or after October 1, 1994, medical supplies, for use by patient in their own home - Reimbursement is based on 100% of the Medicare maximum for medical supplies reflected in the 1993 Arkansas Medicare Pricing File not to exceed the Title XIX coverage limitations as specified in Attachment 3.1-A and Attachment 3.1-B, Item 12.c.7.

Effective for dates of service on or after May 1, 2002, reimbursement is based on a negotiated statewide contract bid.

7. Home Health Services (Continued)

c. Medical Supplies, Equipment and Appliances Suitable for Use in the Home (continued)

(2) Durable Medical Equipment (DME) - Reimbursement is based on amount billed not to exceed the Title XIX maximum.

Purchase: The Title XIX maximum for new equipment is based on Medicare's 1990 DME Fee Schedule. For those items which Medicare did not have a rate, the lowest manufacturer cost plus 10% was used. Arkansas Medicaid is following Medicare's policy of purchasing any item that costs $150.00 or less.

Rental/Capped Rental: Capped Rental equipment may not be rented for more than 455 consecutive days. The reimbursement rates for capped rental items will be established by dividing the purchase price by 455 days to arrive at a daily rental rate. Once the 455 day rental maximum is reached, Arkansas Medicaid will cease to pay rent on the equipment, however the equipment will remain in the recipient's home as long as determined medically necessary by the recipient's physician. The equipment will remain the property of the DME company.

A provider may bill for maintenance, however, this maintenance fee may not be billed until either 182 days have elapsed after the 455 day rental period or 182 days have elapsed from the end of the period the item is no longer covered under the suppliers or manufacturer's warranty, whichever is later. Maintenance will continue to be paid at six-month intervals if equipment is determined to be medically necessary. Reimbursement of the maintenance is the lesser of the amount billed or the Title XIX maximum. The Title XIX maximum was established by arraying all the Title XIX monthly maximums for capped rental items and utilizing the 50th percentile.

For those items which are rental only , the Medicare 1990 DME Fee Schedule monthly rental rate was used to calculate the Medicaid daily rental rate. The Medicare monthly rental rate was multiplied by 12 to determine the one year rental amount and divided by 365 to arrive at the Medicaid daily rental amount.

Effective for dates of service on or after May 1, 2002, reimbursement is based on a negotiated statewide contract bid.

7. Home Health Services (Continued)

c. Medical Supplies, Equipment and Appliances Suitable for Use in the Home (continued)

(3) DME/Nasal CPAP Device

DME/Nasal CPAP Device - Reimbursement is based on the lesser of the provider's actual charge for the service or the Title XIX (Medicaid) maximum. The Title XIX maximum was established based on a 1989 survey conducted by the Division of Medical Services of four Arkansas durable medical equipment companies. Reimbursement for the nasal CPAP device is always on a rental basis only. The rate was established by utilizing the lowest monthly rental rate reflected by the survey. The reimbursement methodology includes a provision for automatic adjustments based on fluctuations in the economy.

Effective for dates of service on or after May 1, 2002, reimbursement is based on a negotiated statewide contract bid.

(4) DME/Bi-Level Positive Airway Pressure (BIPAP) Equipment

Effective for claims with dates of service on or after February 1, 1995, reimbursement is based on the lesser of the provider's actual charge for the service or the Title XIX (Medicaid) maximum. The Title XIX maximum for the BIPAP is based on 100% of the Medicare maximum for equipment and supplies reflected in the 1994 Arkansas Medicare Pricing File. The Medicaid monthly rental rate for equipment was used to calculate the daily rental rate. The BIPAP medical supply rate was established at 25% of the total for all supplies utilized with the BIPAP equipment. Reimbursement is a global rate for equipment, supplies and maintenance.

Effective for dates of service on or after May 1, 2002, reimbursement is based on a negotiated statewide contract bid.

withdrawn per letter dated 5/1/02

7. Home Health Services (Continued)

c. Medical Supplies, Equipment and Appliances Suitable for Use in the Home (continued)

(5) Aerochamber Device

Effective for dates of service on or after October 1, 1997, reimbursement is based on the lesser of the provider's actual charge for the service or the Title XIX (Medicaid) maximum. The Title XIX (Medicaid) maximum established was based on a 1997 survey of Durable Medical Equipment (DME) providers. The information obtained in the survey indicated there is only one major manufacturer and distributor of the aerochamber devices (with or without mask) to providers enrolled in the Arkansas Medicaid Program. It was determined the aerochamber devices are sold to each provider for the same price. As a result, the current Title XIX (Medicaid) maximum for the aerochamber devices (with or without mask) was established based on the actual manufacturer's list prices. Thereafter, adjustments will be made based on the consumer price index factor to be implemented at the beginning of the appropriate State Fiscal Year, July 1.

Effective for dates of service on or after May 1, 2002, reimbursement is based on a negotiated statewide contract bid.

(6) Specialized Wheelchairs, Seating and Rehab Items

Reimbursement is based on the lesser of the provider's actual charge for the service or the Title XIX (Medicaid) maximum. Effective for claims with dates of service on or after May 1, 1995, the Title XIX (Medicaid) maximums were established utilizing the manufacturer's current published suggested retail price less 15%. The 15% is the median of Oklahoma Medicaid which is currently retail less 12% and Texas Medicaid which is currently retail less 18%. Effective for claims with dates of service on or after September 1, 1995, the following Kaye Products, procedure codes Z2059, Z2060, Z2061 and Z2062, are reimbursed at the manufacturer's current published suggested retail price. The State Agency and affected provider association representatives will review the rates annually and negotiate any adjustments.

Effective for dates of service on or after May 1, 2002, reimbursement is based on a negotiated statewide contract bid.

7. Home Health Services (Continued)

c. Medical Supplies, Equipment and Appliances Suitable for Use in the Home (continued)

(7) Augmentative Communication Device

Reimbursement is based on the manufacturer's charges. Providers must submit an itemized manufacturer's invoice with the claim. Reimbursement will include the cost of the device, software, carrying case and maintenance agreement, not to exceed a maximum of $7,500.00 If a recipient under age 21 in the Child Health Services (EPSDT) Program has met the lifetime benefit, and it is determined that additional equipment is medically necessary, the provider can request an extension of benefits. Training in the use of the device is not included and is not a covered cost. Repairs to the equipment or associated items outside the initial maintenance agreement are a covered service. Reimbursement for repairs of augmentative communication device components will be manufacturer's invoice price for parts plus 10%. Arkansas Medicaid reimburses for the labor based on the lesser of the amount billed not to exceed the Title XIX (Medicaid) maximum. The Medicaid maximum was calculated by conducting a survey of three manufacturers of augmentative communication devices who repair state-of-the art devices to the less complex devices. The three manufacturer's current hourly charge for labor was totaled, then divided by 3 to arrive at an average hourly rate. The hourly rate was divided by 4 to arrive at a 15 unit rate. Labor will be reimbursed per unit of service, (1 unit = 15 minutes limited to a maximum of 20 units per date of service allowed).

Effective for dates of service on or after May 1, 2002, reimbursement is based on a negotiated statewide contract bid.

(8) Phototherapy (Bili-rubin) Light with Polometer

Effective for dates on or after May 1, 1999, the reimbursement rate is based on the lesser of the provider's actual charge for the service or the Title XIX maximum. The Title XIX (Medicaid) maximum was based on 100% of the Medicare maximum (daily rental rate) for the Phototherapy (Bili-rubin) Light with Polometer as reflected in the 1999 Medicare DME, Prosthetics, Orthotics and Supplies Fee Schedule. The reimbursement methodology includes a provision allowing adjustments based on fluctuations in the economy. Any adjustment to the rate will be based on the most current Medicare DME, Prosthetics, Orthotics and Supplies Fee Schedule.

Effective for dates of service on or after May 1, 2002, reimbursement is based on a negotiated statewide contract bid.

d. **Physical Therapy**

Refer to Item 4.b.(19).

7. Home Health Services (Continued)

c. Medical Supplies, Equipment and Appliances Suitable for Use in the Home (continued)

(9) Oxygen

Reimbursement is based on the lower of the amount billed or the Title XIX maximum charge allowed.

The Title XIX maximum for the oxygen concentrator, liquid oxygen, liquid oxygen walker and reservoir is based on the DME fiscal year 1981 Medicare Median.

Effective for dates of service on or after May 1, 2002, reimbursement is based on a negotiated statewide contract bid.

(10) Diapers

Reimbursement is based on the lesser of the provider's actual charge for the service or the Title XIX (Medicaid) Maximum. Effective March 1, 1991, the Medicaid Maximum was established based on the median cost for each item. The median cost was determined by surveying three medical supply companies.

Effective for dates of service on or after May 1, 2002, reimbursement is based on a negotiated statewide contract bid.

withdrawn per State's letter dated 7-02

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: May 1, 2002

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist (Continued)

b. Dentures

Refer to Attachment 4.19-B, Item 4.b.(9).

c. Prosthetic Devices

(1) Eye Prostheses - Refer to Attachment 4.19-B, Item 4.b.(13).

(2) Hearing Aids - Refer to Attachment 4.19-B, Item 4.b.(12).

(3) Ear Molds - Refer to Attachment 4.19-B, Item 4.b.(14).

(4) Pacemakers and Internal Surgical Prostheses - Reimbursed at 80% of invoice price.

(5) Hyperalimentation - Reimbursement according to the lower of the amount billed or the Title XIX maximum charge allowed.

withdrawn by State Plan letter dated 3-7-02

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist (Continued)

c. Prosthetic Devices (continued)

(6) Orthotic Appliances and Prosthetic Devices

For Medicaid eligible recipients under age 21, the reimbursement methodology for orthotic appliances and prosthetic devices is based on amount billed not to exceed the Title XIX Maximum. The Title XIX Maximum is based on the Medicare Fiscal Year 1990 DME fee schedule.

For Medicaid eligible recipients age 21 and over the reimbursement is based on the lesser of the provider's actual charge for the services or the Title XIX (Medicaid) Maximum. The Title XIX (Medicaid) Maximum is based on the 1999 Medicare DME, Prosthetics, Orthotics and Supplies Fee Schedule less 18%.

Withdrawn but State per letter dated 3-17-03

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist (Continued)

d. Eyeglasses

Negotiated statewide contract bid.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

a. Diagnostic Services - Not provided.
b. Screening Services - Not provided.
c. Preventive Services - Not provided.
d. Rehabilitative Services

1. Rehabilitative Services for Persons with Mental Illness

Reimbursement is based on the lower of the amount billed or the Title XIX (Medicaid) maximum allowable.

The Title XIX maximum was established based on a survey by the Division of Mental Health of the usual and customary charges used by community based programs. Rates include the professional and administrative components.

For acute outpatient services and acute day treatment previously found in the Mental Health Clinic option, reimbursement is based on the lower of: (a) the provider's actual charge for the services or (b) the allowable fee from the State's fee schedule based on average cost. The average cost of each mental health service was calculated based on 1978 cost data. A 20 per cent inflation factor was applied to arrive at the "fee schedule" rate.

Effective April 1, 1988, reimbursement rates were increased 78% to reflect rates comparable to those charges found in the private sector for comparable mental health services. Effective July 1, 1991, a 20% increase was applied.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services

2. Extended Rehabilitative Services for Persons with Physical Disabilities (RSPD)

a. Arkansas Non-State Operated Rehabilitative Hospitals

Refer to Attachment 4.19-A, Page 9a, for the reimbursement methodology, except no room and board charges will be reimbursed and the upper limit is set annually at the 70th percentile of all non-state operated rehabilitative hospitals' inflation-adjusted Medicaid per diem rate.

b. Arkansas State-Operated Rehabilitative Hospitals

Effective for claims with dates of service on or after 1-1-96, Arkansas State Operated Rehabilitative Hospitals are classified as a separate class group. The Medicaid definition of a state operated rehabilitative hospital is: A hospital that is recognized as a state operated rehabilitative facility.

The per diem reimbursement for Rehabilitative Services for Persons with Physical Disabilities (RSPD) provided by a State Operated Rehabilitative Hospital will be in accordance with the reimbursement methodology in Attachment 4.19-A, Page 9a, except; the initial per diem rate will be capped at $232.00, no room and board charges will be reimbursed and the annual inflation factor will be based on the HCFA Market Basket Index forecasts published by the HCFA Regional Office for the quarter ending in September. The inflation factor used is taken from the Excluded Hospital Input Price Index category. Arkansas Medicaid will review the per diem rate annually and adjust the rate, if necessary, based on the provider's unaudited cost report, and the annual inflation factor.

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services

Not provided.

b. Nursing facility services

Not provided.

withdrawn by State per letter dated 3-7-02

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a qualified provider (in accordance with section 1920 of the Act.)

Reimbursement for these services is described in Attachment 4.19-B, e.g. outpatient hospital, physician services, etc.

22. Respiratory care services (in accordance with section 1920(e)(9)(A) through (C) of the Act).

1. See reimbursement methodology for respiratory therapy services for ventilator-dependent recipients under age 21 on Attachment 4.19-B, Page 1j.

2. Ventilator equipment - Reimbursement is based on the lower of the amount billed or the Title XIX maximum charge allowed.

The Title XIX maximum is based on the following:

(a) The positive pressure ventilator and accessories are based on the LP-6 manufacturer's price (Aequitron Medical - October 1, 1986) for new equipment and 75% of the LP-6 manufacturer's price (Aequitron Medical - October 1, 1986) for used equipment.

(b) The suction pump is based on Medicare's rate in effect in August 1987 for new equipment. Used equipment is based on 75% of Medicare's rate.

(c) The negative pressure ventilator and accessories are based on the manufacturer's price plus 10% for the maintenance, delivery, set up, emergency call, 24/hr/day, 7 day/week availability.

(d) The oxygen concentrator, liquid oxygen, liquid oxygen walker and reservoir, hospital bed and nebulizer are based on the DME Fiscal Year 1981 Medicare median.

(e) The ventilator supplies are based on the manufacturer's price.

The reimbursement methodology includes a provision for automatic adjustments based on fluctuations in the economy.

Effective for dates of service on or after May 1, 2002, reimbursement is based on a negotiated statewide contract bid.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Calvin G. Cline
Associate Regional Administrator, Medicaid and State Operations

1301 Young Street, Room 827
Dallas, Texas 75202
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March 12, 2002

Our Reference: SPA AR-02-03

Mr. Ray Hanley, Director
Division of Medical Services
Arkansas Department of Human Services
P.O. Box 1437 - Slot 1103
Little Rock, Arkansas 72203-1437

Dear Mr. Hanley:

This is to acknowledge receipt of your letter dated March 7, 2002, requesting the withdrawal of State Plan Transmittal No. 02-03 which was to move medical supplies and equipment items from the prosthetic category to the home health category. This action is reflected on the enclosed HCFA-179.

For your convenience, we are enclosing copies of the material withdrawn.

If you have any questions, please call J. P. Peters at (214) 767-2628.

Sincerely,

Peters for

Andrew A. Fredrickson, Chief
Medicaid Operations and Financial Management Branch
Centers for Medicare and Medicaid Services

Enclosures

CMS
CENTERS for MEDICARE & MEDICAID SERVICES